Medicare Advantage Risk Adjustment Programs

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Contents

Part 1: Diagnostic Coding Guidance

This manual provides coding guidance to be used when coding medical records on behalf of Anthem (formerly WellPoint) for Medicare Advantage Risk Adjustment purposes. This manual was created based on specific coding guidance from the following reputable resources:

- Official ICD-9 and ICD-10 Coding Guidelines
- AHA Coding Clinic
- CMS 2008 Risk Adjustment Participant Guide
- Risk Adjustment 101 Participant Guide (2013 National Technical Assistance)
- Chapter 7 Medicare Managed Care Manual

Please refer to these resources for official coding rules and regulations. This manual is intended to address common coding topics seen in the Medicare Advantage population. This manual is not all inclusive; it will be reviewed and updated annually.

Coders should also utilize (current and up-to-date) references such as:

- Medical dictionaries
- Drug references
- AMA and other Anatomy/clinical references (i.e., Merck Manual)
- AHA, AAPC, and AHIMA approved coding and billing education references (e.g., Faye Brown's Coding Handbook, Coder's Desk Reference)
- Internet access for coding and clinical research

Part 2: Overarching Guidance

The intent of all Anthem programs is to report to CMS all conditions that are properly documented and addressed in the member's medical record for each date of service. The information contained in this manual provides parameters and guidance to help achieve this ultimate goal.

Part 3: What Is Medicare Risk Adjustment?

Medicare risk adjustment is the method used to adjust bidding and payment from CMS (Centers from Medicare & Medicaid Services) to Medicare Advantage plans based on demographics (i.e., age and sex) as well as actual health status of enrollee. Medicare risk adjustment is prospective, meaning diagnoses from the previous year and demographic information are used to predict future costs and adjust payment.

The purpose of risk adjustment is to allow CMS to pay Medicare Advantage (MA) plans for the risk of the beneficiaries enrolled. By risk adjusting plan payments, CMS is able to make appropriate and accurate payment for enrollees with differences in expected costs.

3.1 Risk Score

A risk score is created in order to determine how an average member in the population compares to another member in the population. Risk score is based on a combination of demographic and disease data. The demographic data is provided to CMS by the Social Security Administration, while the disease data is submitted by the MA Organization in the form of diagnosis codes.

The formula reads:

Risk Score = (demographics) + (disease) + (disease) + (disease)

CMS uses the following demographic factors when calculating a risk score:

- Age
- Sex
- Frailty
- Disability
- Original Reason for Entitlement (OREC)
- Institutionalization
- Medicaid Status

Total risk adjusted payment starts with the base payment calculated by the MA Plan that is submitted to CMS for approval as part of the Plan's annual bid process. The total payment calculation is:

Total Payment = Base Payment x Risk Score

3.2 HCC/ Diagnosis Groups

The Hierarchical Condition Category (HCC) is a diagnosis grouping with a single relative factor assigned to it for each model segment. The diagnosis grouping consists of clinically related ICD-9 codes that have similarly projected costs. MA plans are paid based on the member's diagnoses codes that map to an HCC. These HCC-related diagnosis codes must be reported at least once during each calendar year for risk adjusted payment. Codes are reported to CMS via the Risk Adjustment Processing System (RAPS). RAPS will be replaced with Enterprise Data Processing System (EDPS) in the near future.

Over 3,100 ICD-9 codes map to 2013 CMS-HCC and/or 2014 CMS-HCC risk adjustment model. There are over 8,700 ICD-10 codes that map to the 2014 CMS-HCC risk adjustment model.

2013 & 2014 CMS-HCC Model Spreadsheet
Preliminary ICD-10-CM Mapping to CMS-HCC Model

3.3 CMS-HCC Risk Adjustment Model

For 2014 payment year, CMS implemented an updated, clinically revised CMS-HCC risk adjustment model. The risk scores for payment year 2014 and 2015 were calculated by blending the 2013 CMS-HCC model and the revised 2014 CMS-HCC model.

For 2016 payment year (2015 dates of service), CMS fully implemented the 2014 CMS-HCC Risk Adjustment Model. For more details on the CMS-HCC models, please refer to CMS' Advance Notice and Final Call Letters.

3.4 Provider Types

For risk adjustment purposes, MA organizations must collect data from the following provider types:

- Hospital outpatient facilities
- Hospital inpatient facilities
- Physicians (refer to table below for acceptable physician specialty types)

Acceptable Physician Specialty Types for 2015 Payment Year (2014 Dates of Service) Risk Adjustment Data Submission

CODE	SPECIALTY	CODE	SPECIALTY	CODE	SPECIALTY
1	General Practice	25	Physical Medicine And Rehabilitation	67	Occupational Therapist
2	General Surgery	26	Psychiatry	68	Clinical Psychologist
3	Allergy/Immunology	27	Geriatric Psychiatry	72*	Pain Management
4	Otolaryngology	28	Colorectal Surgery	76*	Peripheral Vascular Disease
5	Anesthesiology	29	Pulmonary Disease	77	Vascular Surgery
6	Cardiology	33*	Thoracic Surgery	78	Cardiac Surgery
7	Dermatology	34	Urology	79	Addiction Medicine
8	Family Practice	35	Chiropractic	80	Licensed Clinical Social Worker
9	Interventional Pain Management (IPM)	36	Nuclear Medicine	81	Critical care (intensivists)
10	Gastroenterology	37	Pediatric Medicine	82	Hematology
11	Internal Medicine	38	Geriatric Medicine	83	Hematology/Oncology
12	Osteopathic Manipulative Medicine	39	Nephrology	84	Preventive Medicine
13	Neurology	40	Hand Surgery	85	Maxillofacial Surgery
14	Neurosurgery	41	Optometry	86	Neuropsychiatry
15	Speech Language Pathologist	42	Certified Nurse Midwife	89*	Certified Clinical Nurse Specialist
16	Obstetrics/Gynecology	43	Certified Registered Nurse Anesthetist	90	Medical Oncology
17	Hospice And Palliative Care	44	Infectious Disease	91	Surgical Oncology
18	Ophthalmology	46*	Endocrinology	92	Radiation Oncology
19	Oral Surgery	48*	Podiatry	93	Emergency Medicine
20	Orthopedic Surgery	50*	Nurse Practitioner	94	Interventional Radiology
21	Cardiac Electrophysiology	62*	Psychologist	97*	Physician Assistant
22	Pathology	64*	Audiologist	98	Gynecologist/Oncologist
23	Sports Medicine	65	Physical Therapist	99	Unknown Physician Specialty
24	Plastic And Reconstructive Surgery	66	Rheumatology	C0	Sleep Medicine

* Indicates that a number has been skipped.

Part 4: Medical Record Documentation

Medical record documentation is the historical account of the patient/provider encounter and serves as the basis for coding of all diagnoses and services provided to patients. The medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. Consistent, current and complete documentation in the medical record is an essential component of quality patient care. The documentation should be clear and concise to communicate the condition(s) and treatment rendered to the patient.

Medical record documentation assists physicians and other health care professionals in evaluating and planning the patient's immediate treatment and monitoring the patient's health care over time. It is also the basis for collecting data and coding for risk adjustment.

Carefully review the medical record to ensure the following guidelines are met for HCC validation:

- Each coded date of service (DOS) should be able to stand on its own.
- CMS recommends that the patient's name and DOS appear on each page of the record.
    - If the patient's name and DOS do not appear on each page of the record, it is acceptable for coding as long as it is evident that each page of the record is for the same patient and DOS. Coders should carefully review the entire record for context using their best judgment.
- Diagnosis must result from a face-to-face visit either with an acceptable physician specialty or from an acceptable facility.
- Diagnosis must be supported by appropriate medical record documentation that demonstrates TAMPER (refer to section 5.15, Status/Status Post codes, for exceptions).
- Diagnosis must be submitted at least once during a reporting period.
- The provider's signature and credential must comply with CMS requirements (refer to section 5.5, Physician Signature and Credentials, for more details)
- Conditions coded must be stated in the medical record using text. Conditions documented using only numerical ICD-9 codes are not acceptable for risk adjustment per CMS (refer to section 5.16, ICD-9-CM Codes Only, for more details).

The entire medical record should be reviewed at the time of coding to ensure complete code capture of the condition(s) documented by the provider in accordance with the Official Coding Guidelines.

There are regulatory and accreditation directives that require providers to supply documentation in order to support code assignment. Providers need to have the ability to specifically document the patient's diagnosis, condition and/or problem. It is the provider's responsibility to provide clear and legible documentation of a diagnosis, which is then translated to a code for external reporting purposes. (AHA Coding Clinic for ICD-9-CM, 2012, Q1, Volume 29, Number 1, pg 6)

Part 5: Physician/ Outpatient Records

5.1 Hospital Outpatient

Hospital outpatient services are therapeutic and rehabilitative services provided for sick or injured persons who do not require inpatient hospitalization or institutionalization. Covered and non-covered hospital outpatient facilities are listed below.

Covered Facilities
- Short-term (general and specialty) Hospitals
- Medical Asst. Facilities/Critical Access Hospitals
- Community Mental Health Centers
- Federally Qualified Health Centers
- Religious Non-Medical Health Care Institutions
- Long-term Hospitals
- Rehabilitation Hospitals
- Children's Hospitals
- Psychiatric Hospitals
- Rural Health Clinic (Free-standing & Provider-based)

Non-Covered Facilities*
- Free-standing Ambulatory Surgical Centers
- Home Health Care
- Free-standing Renal Dialysis Facilities

Non-Covered Services
- Laboratory Services
- Ambulance
- Durable Medical Equipment
- Prosthetics
- Orthotics
- Supplies
- Radiology Services**

* These are examples of non-covered facilities and are not a comprehensive list.
** Regardless of the type of diagnostic radiology bill (outpatient department or physician component), this hospital outpatient service is not acceptable for risk adjustment because it typically does not contain confirmed diagnoses.

5.2 Coding Exclusions

Documentation acceptable for risk adjustment purposes must be from a face-to-face visit with an acceptable provider type (reference section 3.4 for listing). Do not code the following from Table 5A.

Table 5A Coding Exclusions List, Do Not Code

Lab	Phone calls	Dialysis
Radiology	Physician orders	Prosthetics/orthotics
Ambulance	Charge slips/ Superbills	Ambulatory surgery center
DME/Supplies	Rx scripts	Letters not for a face-to-face visit
Diagnostic/Electro-diagnostic Reports	Nursing notes/Nurse Only Visits	Consultation requests
Chemotherapy only	Infusion Therapy	Visits between provider and family
Skilled Nursing Facility (SNF)		

5.3 Date of Service

The Date of Service (DOS) defines when a beneficiary received medical treatment from a physician or medical facility. For outpatient and physician services, the DOS has to be clear and legible including the month, day, and year. The DOS submitted to CMS must be within the data collection year.

Do not guess or use a default date. Do not interpret the signature date, Date Dictated (DD), Date Transcribed (DT), vitals date or finalized date as the DOS. Exercise extreme caution with progress notes. Do not code the record if the DOS is missing or illegible.

5.4 Date of Birth

The Date of Birth (DOB) does not have to be listed on each date of service. Look for conflicts in comparison that would invalidate the medical record. It is important that coders use their best judgment when reviewing the medical record for DOB. Implement the following best practices when the member's DOB is missing on the date of service:

- Look for patient's age to subtract from the year in the medical record. If the total corresponds with the DOB year in Chart Navigator (based on calculation), the record may be coded.
    - For example: For DOS 05/01/2014, the record states patient's age is 78. Subtract patient's age from the year in the date of service, 2014-78= 1936. The DOB in Chart Navigator is 02/01/1936.
- If the DOB is referenced in other documents within the medical record (e.g., lab or x-ray), the coder may use that DOB for validation. If DOB corresponds, the record may be coded.
- If there is no reference to DOB throughout the entire medical record and the patient's age is not listed, allow the record and code as usual.

Conflicts:

- If there is a modest conflict (i.e., one or two digits, one or two days) in either the DOB or age calculation, allow the record and code as usual.
- If there is a major conflict in the DOB or the member age, do not code the record.

5.5 Physician Signature and Credentials

For risk adjustment purposes, the provider of service for face-to-face encounters is appropriately identified on the medical record via signature and physician specialty credentials.

Examples of acceptable physician signature, including credentials, are:

- Handwritten signature or initials
- Electronic signature with authentication by the respective provider

If electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note. Examples of acceptable electronic signatures are: "Electronically signed by," "Authenticated by," "Approved by," "Completed by," "Finalized by," and "Validated

by" including the practitioner's name, credentials, and date of authentication. If the provider signature is missing at the time of audit, CMS allows for submission of a completed CMS-Generated Attestation for the specific encounter date for an outpatient/physician record. Flag missing signatures appropriately in Chart Navigator.

5.6 Format of Records

Conditions can be coded from *any* part of the medical record provided the condition is documented and appropriately supported with TAMPER (see section 5.8). The two most common documentation formats are:

SOAP

- **S**ubjective - HPI, chief complaint (patient's own words), ROS, reason for the visit
- **O**bjective – physical exam, review of systems, vitals, weight etc.
- **A**ssessment – final impression, symptoms, relevant concurrent problems
- **P**lan - refill meds, order test, refer to specialists, order lab work, treatment plan

CHEDDAR

- **C**hief Compliant – presenting problem(s) in patient's own words
- **H**istory – social, medical, surgical, family histories
- **E**xam – physical examination of the patient
- **D**etails of Problem – details of the complaints or symptoms
- **D**rugs/ Dosages – current medications and dosages
- **A**ssessment – assessment of the diagnostic process and final impressions
- **R**ecommendations – return to clinic, refer to specialist, treatment plan

Keep in mind, not all records follow these formats. Category titles in the medical record vary. For instance, a category titled "History" may indicate past medical history (PMH) or history of present illness (HPI). The main goals are to verify that each encounter is a face-to-face visit with an acceptable provider and that each condition coded has supportive documentation.

5.7 Unconfirmed Diagnosis

For physician and hospital outpatient records, do not code conditions documented as "consistent with," "probable," "possible," "questionable," "rule out," "likely," "suspected," "suspicious for," "working," or other uncertain language. Rather, code the condition(s) to the highest degree of certainty for that encounter such as symptoms, signs, abnormal test results, or other reason for the visit. Refer to the Official ICD-9-CM Guidelines for Coding and Reporting Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services for additional guidance.

The Official Guidelines for Coding and Reporting for Outpatient Services state, "Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)."

5.8 TAMPER/Coding Guidelines per Section

Coders will apply TAMPER guidelines when analyzing each diagnosis and deciding whether that diagnosis meets reporting criteria for each DOS. Coders will look for evidence of treatment as explained by the TAMPER guidelines below.

Treatment: Can be, but not limited to, the following:
- Considered to be Medications
- Education

Assessment: Can be, but not limited to, the following:
- Included as part of the final assessment
- Part of the Assessment with other notation (i.e., "stable", "active", "present")

Monitoring: Can be, but not limited to, the following:
- Laboratory Orders/Results
- Routine follow up visits
- Home monitoring

Plan Can be, but not limited to, the following:
- Decrease medication/increase medication
- Routine follow up visits
- Home monitoring
- Case Management
- Disease Management

Evaluate: Can be, but not limited to, the following:
- Evaluation of current medical regimen
- Physical Examination
- Evaluation for treatment
- Vaccine Titers
- Diagnostics for effectiveness of care and resolution of disease
- Monofilament testing for disease detection

Referral Can be, but not limited to, the following:
- Referral to specialist for treatment
- Referral to dietician

If any one of the above actions is documented, coders should capture and report the diagnosis code(s). Every diagnosis and date of service must stand alone. See below for coding guidelines pertaining to each section of the medical record.

HPI (History of Present Illness) and Chief Complaint

- Conditions documented under HPI or as the chief complaint should be coded as long as there is evidence that the condition is current and confirmed by the provider (i.e, not documented as probable or as hearsay from the patient).

PMH (Past Medical History)/Problem Lists

- Chronic conditions in these areas require TAMPER in order to be extracted for risk adjustment. If no TAMPER exists then the code should not be extracted.

ROS (Review of Systems)

- Conditions documented under ROS should be coded as long as there is evidence that the condition is current and confirmed by the provider (i.e, not documented as probable or as hearsay from the patient). Conditions(with the exception of status codes) in these areas require TAMPER in order to be extracted for risk adjustment.

Physical Exam

- The physical exam is considered TAMPER. Current conditions documented here should be captured as they are the objective findings from the face-to-face encounter with the patient. Conditions here should only be coded if they are documented as a confirmed diagnosis and not just a description (i.e., patient appears hypoxic).

Assessment/Plan

- All conditions listed here are considered to meet TAMPER and should generally be coded. Chronic conditions listed under the assessment/plan are considered to meet TAMPER and should be coded. Keep in mind that some conditions, such as cancer, require current treatment in order to be coded as active and not history of. Acute conditions (e.g., stroke, fracture, MI, etc.) will always require TAMPER.

5.9 Chronic Conditions

Below are examples of chronic conditions that can be extracted from HPI, ROS, Physical Exam, and Assessment/Plan.

Table 5B Chronic Conditions (not an all inclusive list)

Atrial Fibrillation	Chronic Osteomyelitis	End Stage Liver Disease	Peripheral Vascular Disease
Bipolar Disorder	Chronic Pancreatitis	Epilepsy	Pulmonary Heart Disease
Cardiomyopathy	Chronic Resp. Failure	HIV/AIDS	Quadriplegia
Cerebral Palsy	Chronic Skin Ulcer	Ischemic Heart Disease	Rheumatoid Arthritis
Chronic Bronchitis	Cirrhosis of the Liver	Major Depressive Dis.	Schizophrenia
Chronic Hepatitis	Congestive Heart Failure	Multiple Sclerosis	Systemic Lupus Erythem.
Chronic Kidney Disease	Crohn's Disease	Muscular Dystrophy	Ulcerative Colitis
Chronic Nephritis	Cystic Fibrosis	Paraplegia	
Chronic Leukemia	Diabetes Type 1 & 2	Parkinson's Disease	
COPD	Emphysema	Peripheral Neuropathy	

Medical history alone may not be used as a source of diagnoses for risk adjustment purposes. For a chronic condition to be accepted for risk adjustment, the patient must have a face-to-face visit each year with a provider/physician who assesses and documents that condition. (2013 National Technical Assistance, RA 101 Part Guide, Pg 17)

5.10 Acute/Emergency Conditions in Physician's Office

Patients with life threatening conditions are not likely to be treated in the physician's office. Upon review, it is often discovered that documentation is describing the historical event rather than a current (acute) condition. Use the following list as a guide if it appears that an acute, emergent event has been documented in the office visit. Keep in mind that historical conditions that have no bearing on current care are not coded. TAMPER applies to all acute conditions.

Table 5C Coding Acute Conditions (not an all-inclusive list)

Code	Acute Condition(s)	Coder Action
411.1	Unstable Angina, Acute Coronary Syndrome	Assign a code for the underlying condition if documentation supports, such as CAD.
434.xx 436	Occlusion of cerebral arteries Acute, but ill-defined, cerebrovascular disease	Assign code V12.59 for history of CVA if no residual conditions remain. If the provider documents a late effect and cause (e.g., hemiplegia due to CVA) then use the late effects category 438.xx.
410.x1 410.x0	Acute Myocardial Infarction (initial episode of care) Acute Myocardial Infarction (unspecified episode of care)	Look for the date of the event. If the patient is ≤ 8 weeks status post MI, it is acceptable to code 410.x2 for subsequent follow up care. Assign code 412 if the patient had an MI > 8 weeks ago.
518.5 518.81 518.82 518.84	Pulmonary insufficiency following trauma and surgery Acute respiratory failure Other pulmonary insufficiency, NOS Acute on chronic respiratory failure	Assign a code for the underlying pulmonary condition with supporting documentation, such as COPD.

5.11 Specialists

For specialist (Cardiologist, Ophthalmologist, Endocrinologist, etc.) encounters, all confirmed conditions documented in the HPI, ROS, Exam, and/or assessment that pertains to the specialist's field should be captured as long as there is no evidence of contradiction in the medical record. The specialist is following up on conditions that the PCP does not. They perform specific examinations and tests that would constitute as TAMPER for those conditions related to the specialist's field. It would also be appropriate to code co-existing conditions as long as there is supportive documentation for that condition. As a reminder, do not code from PMH alone without TAMPER.

5.12 Inferring a Diagnosis

Coder's must be careful to not infer a diagnosis that has not been stated by the provider. For example, Coumadin is listed as a current medication but the condition for which Coumadin is being taken is not stated. It would be incorrect for the coder to infer that the patient has atrial fibrillation based solely on the medication. Also, coders must not assign diagnoses based solely on findings (lab, x-ray, etc.). **The provider must specifically state the condition in the documentation in order for it to be coded.**

5.13 "History of"

According to ICD-9-CM, the phrase "history of" means the patient no longer has the condition and the diagnosis often indexes to a V-code not in the HCC models. However, physicians often use this phrase to indicate the length of time for which a member has been treated for a condition. Use the context of the entire medical record to determine whether the condition is active with current treatment or historically resolved.

5.14 Problem Lists

Problem lists rarely contain the required elements as described by CMS. In general, it is felt that they should be avoided as a source of diagnosis coding. **Do not code from the problem list or PMH unless there is TAMPER that can be attributed to the condition.** Carefully review the documentation, including dates (if listed) to ensure that the condition is not historically resolved.

Although the term 'problem list' is commonly used with regard to ambulatory medical record documentation, a universal definition does not exist. The problem list is generally used by a coder to gain an overall clinical picture of a patient's condition(s). Problem lists are usually supported by other medical record documentation such as SOAP notes (subjective, objective, assessment, plan), progress notes, consultation notes, and diagnostic reports.

For CMS' risk adjustment data validation purposes, an acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service, and it must be signed and dated by the physician or physician extender. (2008 Risk Adjustment Participant Guide, 7-17, p172).

5.15 Status/ Status Post Codes

Per ICD-9 Guidelines, "Status codes indicate that a patient is a carrier of a disease, has the sequelae or residual of a past disease or condition, or has another factor influencing a person's health status. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition." The status code may not affect the course of treatment indicating an exception to the TAMPER criteria.

Status codes may be coded from *any* part of the medical record as long as there is evidence of the condition. Coders are again cautioned with coding from PMH alone; validate that the condition and/or presence of device is a current status and not historical when able. Typically ostomies, amputations, and devices are documented in the physical exam for confirmation of current status.

Listed below are status/status post codes that link to an HCC:

- organ transplant status such as lung, liver, stem cell, etc.
- HIV status
    - *Note: Per ICD-9 Guidelines, "V08 Asymptomatic human immunodeficiency virus [HIV]*

infection is to be applied when the patient without any documentation of symptoms is listed as being "HIV positive;' "known HIV;' "HIV test positive:' or similar terminology. Do not use this code if the term "AIDS" is used or if the patient is treated for any: HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use 042 in these cases. Patients previously diagnosed with any HIV illness (042) should never be assigned to 795.71 or V08."

- heart assists devices/artificial heart
- renal dialysis
  - *Note: Must be documented as currently receiving dialysis in order to code V45.11 for renal dialysis status. Assign the renal dialysis status code for the presence of an AV (arterial-venous) shunt only when documentation specifies it is for dialysis.*
- ventilator status
- long term use of insulin
  - *Note: Use only as secondary to type II diabetes.*
- old Myocardial Infarction (refer to Table 7B for common terms associated with MI)
- artificial/stoma openings such as tracheostomy, gastrostomy, etc.
  - *Note: Must be documented as currently present. Look for words such as "takedown" or "reanastomosis" to indicate the ostomy no longer exists.*
- amputations of lower extremity such as toe, BKA, and AKA
  - *Note: Traumatic amputation should only be coded for acute treatment. If the patient had a traumatic amputation of the lower extremity in the past, correct coding would fall under the V49.7x category*
- hemiplegia/ hemiparesis
  - Note: *If late effect of CVA, must be documented with linking verbiage*

5.16 Legibility

Documentation should be clear and legible. Do not assume or guess a diagnosis. Only code the conditions that are clearly documented and supported in the medical record.

At a minimum the following items must be clear and legible:

- DOS including month, day, and year
- Member's first and last name
- Diagnosis
- Supportive TAMPER

If in doubt, please have another coder/supervisor review the record for legibility.

5.17 ICD-9-CM Codes Only

Some physician records contain only ICD-9-CM codes without the code's description. For risk adjustment purposes, there must be documentation of the condition elsewhere on that DOS. If the record does not document the condition (other than just listing the ICD-9-CM code), do not code.

Remember: The clinician must document the condition in the medical record in order for code assignment. Refer to ICD-9 coding guidelines and other reputable resources previously listed for further guidance.

Part 6: Inpatient

6.1 Hospital Inpatient

Hospital inpatient services include those for which the patient is admitted to the facility for at least one overnight stay. Covered and non-covered hospital inpatient facilities are listed below.

Covered Facilities:
- Short-term (general and specialty) Hospitals
- Religious Non-Medical Health Care Institutions
- Long-term Hospitals
- Rehabilitation Hospitals
- Children's Hospitals
- Psychiatric Hospitals
- Medical Assistance Facilities/ Critical Access Hospitals

Non-Covered Facilities*:
- Skilled Nursing Facilities (SNFs)
- Hospital Inpatient Swing Bed Components
- Intermediate Care Facilities
- Respite Care
- Hospice

** These are examples of non-covered facilities and not a comprehensive list.*

6.2 Inpatient Records

In order to code an encounter as an inpatient record there must be a valid discharge summary containing both the admission and discharge dates. Per ICD-9-CM Inpatient Coding Guidelines, "*If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out", code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.*" Additionally, diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.

Listed below are a few rules to consider when coding for Inpatient Records:

- A discharge summary is considered a valid document to code for an inpatient record if both the admission and discharge dates are listed. Use inpatient coding guidelines.
- CMS has strict guidelines for submitting History & Physical (H&P) as stand-alone documentation. Refer to 2008 CMS Risk Adjustment Participant Guide section 6.4.3.1 History and Physical (H&P), and Lab and Pathology Reports- Guidance for more details.
- Emergency room visits on the day of admission, operative reports, inpatient consults, H&P, and inpatient progress notes may be coded:
  - In combination with a valid discharge summary using inpatient coding guidelines, *or*
  - Separately using outpatient coding guidelines

Inpatient Coding Advise: Chronic conditions such as, but not limited to, hypertension, Parkinson's disease, COPD, and diabetes mellitus are chronic systemic diseases that ordinarily should be coded even in the absence of documented intervention or further evaluation. Some chronic conditions affect the patient for the rest of his or her life and almost always require some form of continuous clinical evaluation or monitoring during hospitalization, and therefore should be coded. (AHA Coding Clinic for ICD-9-CM, 2007, 3Q, p14)

Part 7: Condition Specific Coding Guidance

7.1 Cancer

If documentation is not clear whether a neoplasm is benign or malignant, use the alphabetic index to find the morphological term used to describe the behavior of the neoplasm. For example, the term leiomyosarcoma is indexed to malignant neoplasms while lipoblastoma is indexed to benign neoplasms in the ICD-9-CM code book.

7.1.1 Current Cancer vs. History

Clinicians may document cancer in historical terms. Coders must refer to the entire document for each DOS to determine whether the malignancy should be coded history, using a V-code, or current. **Documentation must show clear presence of current disease to code current malignancy.** Instances in which the malignancy should be coded as current are noted below.

1. Document indicates either the patient or physician chose not to treat the cancer (e.g. choosing not to continue treatment of a terminal disease) OR

2. Document shows evidence of current/ongoing treatment of the disease:
   - Chemotherapy (e.g. antineoplastic medications)
   - Radiation therapy (e.g. including radioactive seed implantation to provide continuous ambulatory radiation)
   - Suppressive therapy (e.g. hormonal therapy, like Lupron for advanced prostate cancer)
   - Surgical treatment (e.g. a preoperative examination prior to colectomy)
   - Immunotherapy/Biological therapy (e.g. Herceptin therapy for breast cancer)
   - Other Adjuvant therapies

3. Documentation shows that current treatment is being temporarily stopped for the following reasons :
   - To determine an appropriate or alternate treatment plan for the patient's cancer
   - To allow the patient to rest clinically from the effects of treatment (chemo/radiation)
   - To transfer of care where treatment is to be continued by another provider

For coding purposes, cancer is considered "history of" after definitive surgical treatment and/or completion of treatment regimen **unless there is documented evidence of residual disease/ treatment.** Reference chapter 2 of the ICD-9 Coding Guidelines for more specific details for coding neoplasms.

Per RADV Medical Record Checklist and Guidance, "Pay special attention to cancer diagnoses. A notation indicating 'history of cancer,' without an indication of current cancer treatment, may not be sufficient documentation for validation."

7.1.2 Primary vs. Secondary

Metastatic from = Primary

For Example: Malignancy of the colon metastatic from prostate.

- Prostate cancer is primary.
- Colon cancer is secondary.

Metastatic to = Secondary

For Example: Breast cancer with metastasis to the mediastinal lymph nodes.

- Breast cancer is primary.
- Mediastinal lymph nodes cancer is secondary.

If the documentation only states "metastatic" assign the primary malignancy along with code 199.1 for secondary malignancy of unspecified site. (Faye Brown's ICD-9-CM Coding Handbook 2011, pg. 381)

For coding purposes, if a malignancy is not specified as primary or secondary it is assumed to be primary. The following sites are exceptions; they are classified as secondary when not otherwise specified in the documentation:

- Bone
- Brain
- Diaphragm
- Heart
- Liver
- Lymph nodes
- Mediastinum
- Meninges
- Peritoneum
- Pleura
- Retroperitoneum
- Spinal cord

The liver has 3 possible morphological designations:

- Liver, primary – code 155.0 (HCC 8/9*)
- Liver, secondary – code 197.7 (HCC 7/8)
- Liver, not specified as primary or secondary – code 155.2 (HCC 8/9)

* Note: HCC 2013/HCC 2014

7.1.3 In Remission

The following definitions of "remission" are provided by the National Cancer Institute:

- Remission – a decrease in or disappearance of signs and symptoms of cancer
- Partial Remission – some, but not all, signs and symptoms of cancer have disappeared
- Complete Remission – all signs and symptoms of cancer have disappeared, although cancer may be in the body

Lymphoma patients who are "in remission" are still considered to have lymphoma and should be assigned the appropriate code from categories 200-202 (AHA Coding Clinic for ICD-9-CM, 1992, 2Q, p3).

When coding cancer, ICD-9 guidelines state that there must be current treatment aimed at the malignancy in order to assign a current cancer code. Lymphoma "*in remission*" represents an exception to that rule. Lymphoma stated as "*in remission*" is coded as current from categories 200-202 per AHA Coding Clinic reference above. It is inappropriate to assign a history code for lymphoma when specified as "*in remission*."

Do not to confuse lymph node metastasis with lymphoma. Physicians may document lymph node involvement in a patient with lymphoma. It is incorrect to assign category 196 (secondary and unspecified malignant neoplasm of lymph nodes) in this case.

When coding other hematopoietic neoplasms/malignancies classified to codes 203-208 (i.e. plasma cell leukemia) assign the correct fifth digit to indicate the appropriate stage of the disease based on documentation in the medical record.

Table 7A Fifth Digit Classification

Fifth digit	For use with ICD-9 categories 203-208
0	Without mention of having achieved remission
1	In remission
2	In relapse

7.1.4 In-Situ

A neoplasm described as in-situ (codes 230-234) has not metastasized or spread to any other area of the body. The ICD-9-CM coding guidelines offer specific guidance via the index. **A neoplasm described as both in-situ and secondary, represents a conflict in the medical documentation.** Use sound coding judgment and context to determine the appropriate behavior of the neoplasm based on past medical history and treatment (surgical/ radiation/ chemotherapy) documented along with TAMPER to support the chosen code.

- **Dysplasia** – earliest form of pre-cancerous lesion recognizable in a biopsy by a pathologist. Dysplasia can be low grade or high grade. The risk of low-grade dysplasia transforming into cancer is low. Per ICD-9 index reference the term dysplasia, followed by the correct anatomical site.
- **Carcinoma in situ** – neoplasm that has stayed in the place where it began and has not spread to neighboring tissues (e.g., squamous cell carcinoma in situ). The term is synonymous with high-grade dysplasia in most organs.

7.2 Myelodysplastic Syndrome/Myelodysplasia

Myelodysplasic Syndrome, code 238.75 (HCC 44/46), is sometimes confused with congenital myelodysplasia of the spine, code 742.59 (HCC 69/72), a birth defect. Myelodysplasic syndrome (MDS, myelodysplasia) is a group of blood disorders associated with low blood count; it is more common among the elderly population versus the congenital spine defect. Use context and coding judgment to determine correct code.

7.3 Diabetes

Coding for diabetes is a four-step process in which coders must have key pieces of information in order to make accurate code selections:

- Type of Diabetes – type 1 (juvenile) or type 2 (adult onset)
  - Default is type 2 if unspecified
- Status of Control – controlled vs. uncontrolled
- Associated Manifestations – complications or manifestations of diabetes must be documented with linking verbiage to display causality
- Insulin Use – code *only* as secondary to type II diabetes
  - Code as secondary to type I DM, if desired. Type 1 diabetics must use insulin because their pancreas does not produce insulin naturally. Thus, unnecessary to assign V58.67.

Note: *Coder's should never assign a code for diabetes 250.xx when the physician documents abnormal glucose, impaired fasting glucose, or impaired glucose tolerance test. A laboratory test showing one reading of high blood sugar is not considered sufficient "clinical evidence" of diabetes. These conditions are laboratory findings and have designated codes for reporting 790.21 – 790.29. Additionally, the diagnosis of "pre-diabetes" also falls under code 790.29.*

7.3.1 Demonstrating Causality

Conditions listed with a diagnosis of diabetes mellitus or in a diabetic patient are not necessarily complications of the diabetes (AHA Coding Clinic, 1991, Q3, p7-8)

Diabetic complications require two or more codes to fully describe the conditions. **Assign a code for both "diabetes with ___ manifestation" in addition to the specific diabetic complication as instructed by ICD-9 coding guidelines.**

There must be a documented cause-and-effect relationship between diabetes and the associated manifestation in order to select a code from HCC categories 15-18. If documentation does not properly link the two conditions, default to diabetes without complication code 250.0x (HCC 19).

Look for linking verbiage such as:

- Diabetic coma
- Gastroparesis in diabetes
- Foot ulcer associated with diabetes
- Nephropathy due to diabetes
- Blindness of diabetes

** This is not an all-inclusive list of terms. The cause-and-effect relationship must be clearly documented with supportive TAMPER*

Gangrene and osteomyelitis are exceptions to the cause-and-effect rule above. ICD-9-CM assumes a causal relationship between osteomyelitis/gangrene and diabetes when both conditions are present, unless the physician has indicated in the medical record that the acute osteomyelitis or gangrene is totally unrelated to the diabetes (AHA Coding Clinic, 2004, Q1, p 14-15).

7.3.2 Diabetes "with"

Question: What are the code assignments for a diagnostic statement of diabetes with neuropathy? Answer: Assign code 250.6X, Diabetes with neurological manifestations, and code 357.2, polyneuropathy in diabetes, for diabetes with neuropathy. Words such as "with," "with mention of," "associated with," and "in" indicate that both elements in the title must be present in the diagnostic statement or procedural statement. Although they do not necessarily indicate a cause-effect relationship, they occur together much of the time and the classification system indicates this relationship. (AHA Coding Clinic, 2008, Q3)

In ICD-9-CM's Alphabetic Index, the subentry term 'with' means associated with or due to. For example, if the provider documents "diabetes with neuropathy," assign codes 250.6X (diabetes with neurological manifestations) and 357.2 (polyneuropathy in diabetes). (AHA Coding Clinic, 2009, Q2)

Coders need to be cautious with vague terms such as "with" ensuring that the medical record supports a diabetic manifestation. The Coding Clinic question pertains to the diagnostic statement of diabetes with neuropathy.

- If HPI states, "diabetes with CKD, CAD, and hypertension" this would not be considered linked as it is not the diagnostic statement. Additionally, it is unclear as to whether CKD is a manifestation of diabetes since there are multiple conditions included in the sentence.
- If Assessment states, "diabetes with CKD- follow with nephrologist." This would be considered linked since it is the diagnostic statement and there is supportive documentation for the diabetic manifestation.

The Coding Clinic examples of "with" is between diabetes and a specific condition, neuropathy. Diabetes with neurological, ophthalmic, renal, or peripheral circulatory manifestation/complications must include the specific condition that falls under that category in order to additionally code the manifestation.

For instance, the diagnostic statement reads, "diabetes with renal manifestations." What renal manifestation?

- Chronic Kidney Disease
- Diabetic Nephropathy
- Diabetic Nephrosis
- Intercapillary Glomerulosclerosis
- Kimmelstiel-Wilson Syndrome

If it is unclear as to what the specific diabetic manifestation is, default to diabetes without complication code 250.0x (HCC 19).

7.3.3 Diabetic Examinations

If the patient is being seen for a *diabetic* eye or foot exam, it would be appropriate to code the confirmed diabetic manifestation.

- During the diabetic eye exam, the patient is diagnosed with PDR (proliferative diabetic retinopathy). It would be appropriate to code 250.50 and 362.02 for this encounter as instructed by ICD-9 guidelines (code first diabetes).

- During the diabetic foot exam, the patient is diagnosed with Diabetic Peripheral Neuropathy. It would be appropriate to code 250.60 and 357.2 for this encounter as instructed by ICD-9 guidelines (code first underlying disease).

Common forms of TAMPER for diabetes include, but are not limited to:

- A1C – blood test checks how well your diabetes has been recently controlled
- Oral Glucose Tolerance Test or Plasma Glucose Test – a blood test given after more than 8 hours of fasting followed by a dose of glucose, additional testing is then performed to determine the level of glucose that remains in the blood.
- Documenting the review of home blood sugars
- Insulin – currently used or prescribed (code V58.67 in addition to diabetes type II)

7.4 Peripheral Neuropathy

Peripheral neuropathy, code 356.9 (HCC 71/no HCC) is a result of nerve damage, often causing numbness and tingling in the hands and feet. One of the most common causes of peripheral neuropathy is diabetes.

Assign code 356.9, Polyneuropathy unspecified, for peripheral neuropathy of both extremities. Because the disease is affecting multiple nerves, this would be classified as a polyneuropathy. (AHA Coding Clinic, 2013, Q1)

7.5 Morbid Obesity/Body Mass Index (BMI)

Morbid obesity, code 278.01 (no HCC/22), is defined in ICD-9-CM as a BMI of 40 or greater (based on WHO criteria). BMI codes V85.4x (no HCC/22) should only be assigned as a secondary diagnosis when a clinical condition has been stated by the provider. According to the ICD-9-CM codebook, when coding for overweight and obesity an additional code should be used to identify the BMI, *if known*. Ensure that the BMI supports the corresponding diagnosis of morbid obesity.

Individuals who are overweight, obese, or morbidly obese are at an increased risk for certain medical conditions when compared to persons of normal weight. Therefore, these conditions are always clinically significant and reportable when documented by the provider. (AHA Coding Clinic, 2004, Q3)

If the BMI has clinical significance for the patient encounter, the specific BMI value may be picked up from the dietitian's documentation. The provider must provide documentation of a clinical condition, such as obesity, to justify reporting a code for the body mass index. To meet the criteria for a reportable secondary diagnosis, the BMI would need to have some bearing or relevance in turns of patient care. For reporting purpose, the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring: Clinical evaluation, or Therapeutic treatment, or Diagnostic procedures, or Extended length of hospital stay, or Increased nursing care and/or monitoring. Once the provider has provided documentation of the clinical condition, such as obesity, the coder can use the dietitian's note to assign the appropriate BMI codes from category V85 (AHA Coding Clinic, 2006, Q4)